Study on Decentralized Approach to In-Service Training (IST) within the Health and Population Sector Programme (HPSP)

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EXECUTIVE SUMMARY

Background

The Bangladesh Health and Family Planning Program has made a major shift, adopted a strategy: " Health and Population Sector Strategy (HPSS)" with an integrated program called HPSP since July 1998. The strategy emphasized restructuring of health and population system including the unification and redesigning of services at the upazilla level and below. It has also targeted to provide 'one stop' essential services package (ESP) through the service outlets. The HPSP design involved implementation of reorganized and decentralized services even further – from upazilla and union level to nearest doorstep point – aiming at more efficient use of existing personnel involved in delivering services. Massive human resource development including in-service training of different categories of service providers emerged as a pivotal need for successful implementation of the strategy and sectoral program. The Ministry of Health and Family Welfare (MOHFW) has adopted a decentralized approach to in-service training (IST) within the Health and Population Sector Program (HPSP) to meet the emerging needs of human resources development.

In view of the facts stated above, the study was commissioned with the **objective** of documenting the experiences and lessons learnt and making recommendations for improving IST, and to formulating a **vision** for sustainable IST.

2. Methodology of the Study and Limitation

The study has been conducted by Human Development Research Center (HDRC) using qualitative approaches. The study design and selection of six sample districts, one from each of six Divisions and six Upazillas, one from each of the selected Districts have been identified in consultation with LD-IST and HRD-GTZ. The field visits including group discussions were conducted by a team of four experts with District Training Coordination Committee (DTCC) and District/Upazila Training Team (D/UTT) members, Principals and faculty members of FWVTIs, field service providers, and clinical service providers. Community Clinics have been visited, and discussions conducted with HAs and FWAs at their working sites.

The present study encompasses multifaceted nature of work. There were however, certain limitations of the study as a part of the whole process. The limitations were: (a) the time allocated for field work was very minimum to meet the purpose; (b) 'Quality' though an important aspect of training was not envisaged in the TOR, as such it was not assessed; and (c) the study would have been more focussed and informative if the team could observe the real training situation to assess training needs. It may be noted that no training was going on during field visits except at Barisal (Babuganj).

3. Findings from Review of Policy and Program Documents

a. **Four major fields of training** – Orientation, Basic course on ESP, ESP clinical skills training and TOT – have been identified for personnel working in the sector at Upazilla and below. There has been an achievement of sixty one percent of the planned activities in terms of '21 Day Basic Training for Field Service Providers' during financial year 2000-2001. More than 18,000 field service providers (FWA and HA) and their supervisors (FPI, HA, AHI, HI and SI) have received the basic training. However, the Annual Program Review of HPSP (October/November, 2001) stated that only 31 percent of the targets related to ESP training (2000-2001) of different categories of health personnel have been achieved. **The APR, 2001 pointed out that the implementation rate was below expectation. Delay in releasing of pool fund, lack of logistics at UHCs for delivery of training had been identified as major factors for poor achievement.**

b. There was **no integrated planning for in-service training before the HPSP.** Earlier, each of the projects had been implementing training programs separately for respective projects. Training programs appeared more expensive, less organized and least coherent.

   In order **to institutionalize the capability and capacity** to organize, manage, conduct and evaluate in-service training program for the health and population sector, decentralization of technical and institutional capabilities and capacities at Upazilla and below, a national strategy and guideline for Decentralized IST has been adopted.

c. The **newly introduced system of decentralized-IST through DTCC and D/UTT** was evolved after conducting three pilots. It also helped to workout an effective mechanism to overcome the interdepartmental coordination problems between health and family planning department at the district and upzilla level.

4. Findings from Field Visit

a. **Two types of training,** namely the Basic ESP Course for Field Service Providers and Orientation of Paramedics on ESP were imparted locally under decentralized-IST. The orientation of paramedics (SACMO, MA, FWV, SSN and Medical technologists) was conducted by FWVTIs; and training of field service providers conducted mostly in respective upzillas and implemented by D/UTT under the guidance of DTCC. In some instances (Tangail and Barisal) the same have been conducted through FWVTIs as well.

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b. Current status of DTCC, D/UTT

DTCC and D/UTT have been constituted in all the districts and upazillas. Some positions of member are vacant due to transfer/retirement.

Some DTCCs co-opted MO(CS) and MO(CC) in the committee in consultation with TTU. As explained by the members of the committee, in all places, holding of such meetings had been related to actual conduction of decentralized in-service training activities. However, the members opined that the scenario would have changed if training activity could be made a part of regular activity. The FWVTIs/RTCs have not been contacted to send their representatives to D/UTT. **Initiatives lacking on the part of both the partners in ensuring close collaboration. The Principal of respective FWVTI, MATS and Nursing Schools could be co-opted as members of DTCCs. Such inclusions might lead to better mobilization of locally available training resources and expedite the pace of training program.**

c. Unmet Training Needs

The discussions with DTCC and D/UTT members, and the service providers at upazilla level and below revealed that, beside the planned "Basic ESP Course for field Service Providers" and "Orientation of Paramedics on ESP", **there exists a huge unmet need for training to improve the skills for providing ESP services, especially to ensure quality health services as specified in HPSS and HPSP PIP documents.**

Regarding the unmet training needs in the light of quality ESP services delivery they opined that the 'Basic ESP Course for Field Service Providers' which included nine theoretical sections (including Reproductive Health, Child Health Care, Communicable Disease Control and newly emerging diseases, Limited Curative Care, Behavior Change Communication, and Nutrition) **have to be completed on priority basis.** The DTCC and D/UTT members suggested comprehensive courses for individual categories of service providers for developing new skills, updating and enhancing the old skills.

d. Management of Training

Field information revealed existence of three types of training management: (1) the training completely managed by D/UTT at UHC under the guidance of DTCC, (2) management of training contracted out to a Lead Training Organization (LTO), and (3) management by FWVTI involving DTT and DTCC members. In most places the training for field service providers are managed by D/UTT; UFPO of concerned upazilla act as training coordinator. DTCC provides overall guidance. In the second type of training management it has been contracted out by TTU to a lead training organization (LTO). The LTO organizes the training program, provides the service of training coordinator and other support services. DTCC and D/UTT in such instances act as resource pool. The fund in such case is channelled through the LTO. The orientation for paramedics (5 day training Program) has been contracted out to NIPORT (one of the LTOs from government sector) and was held at FWVTIs.

For upazilla level trainings, the UFPO, except few exceptions, acts as training coordinator. The premises of UHC generally in such instances are being utilized as training venue. It has been observed that upazillas, except those with FWVTI/RTCs, generally do not have the residential accommodations for the trainees. **More than half of the upazillas do not have well equipped training rooms, and required logistic support including furniture, audio-visual equipment, white boards etc.** However, the former TFIPP districts/upazillas have the necessary infrastructure with training room and other facilities. It has been found that HRD component of GTZ provided 100 upazillas with Overhead Projectors and multi purpose white boards.

e. Funding

Discussions with DTCC and D/UTT members revealed that **fund flow is the main factor affecting** the total process of implementation of decentralized IST program. The system of funding from Pool fund is not effectively functioning. **The fund flow is irregular**. Lack of availability of fund on regular basis is the single most important factor affecting planned implementation of in-service training courses including the holding of DTCC and D/UTT meetings, preparation of training plans and their execution in compliance with the plan.

f. Allocation of Lecture Sessions

The allocation of training sessions by categories of resource persons (by designation) has been reported to be made and determined from the top by TTU. **A considerable number of informants expressed their opinion in favour of more flexibility to be assigned to respective DUTTs.**

The information provided by DTCC and D/UTT members and also collected through interactions with the trainees revealed that the case load for practical learning is in general sufficient. There are instances that trainees were taken to district hospitals, UHCs and MCWCs for demonstrations and practical learnings.

g. Training of Trainers and their Performance

Most of the DTCC members have received orientation and D/UTT members TOT on Basic ESP Course for Field Service Providers. A few instances have been reported where some of the personnel have not received the TOT. Transfer of relevant officer, promotion and new recruitment are the reasons behind not receiving TOT or orientation. There exists a mechanism at TTU which updates the training needs and the process of organizing TOT. TOT has enriched trainers individual capability.

It has been observed that more than half of the training needs for the basic course has been met since inception of HPSP. In general, most of the upazillas will be requiring two or three more batches to get the service providers and their field level supervisors trained.

The 5-Day Orientation on HPSP for Paramedics being implemented under decentralized-IST has started in July 2001. The training has been contracted out to NIPORT being implemented by FWVTIs for their respective catchment areas. Most of the FWVTIs visited by the study team have reported of completing 4 to 5 batches (each batch comprising 25 participants).

h. Coordination

DTCC and D/UTT formed by TTU have been observed to be effective mechanism for coordination, implementation and monitoring of local level training activities. It is to be noted that the role of trainer and organizer of training Program at the upzilla level is comparatively new for the members who earlier had the experience to work only as clinical service providers or managers. The members have been found capable and enthusiastic for accomplishing their assigned roles.

FWVTIs though not involved directly with DTCC and/or D/UTT have become an important part of in-service training Program held at the district level.

i. Future Training Needs

The participants of group discussions shared their views regarding needs for further training of different categories of field service providers and their supervisors. Based on best judgment of the study team cross checked with DTCC/D/UTT members and relevant knowledgeable persons involved in health and population sector training, the following quantitative estimates in terms of **number of total trainee days** by categories have been identified. The training areas include different components and sub-components of ESP management and facilitative supervision, and record-keeping/ reporting. The estimates are in addition to the 21 days basic training on ESP.

The estimated total additional (in addition to 21 days basic training on ESP) training requirement for the FWAs, HAs AHIs, HIs, SIs, and FPIs would be about 1,855,024 trainee days.

trainee days for FWA (23,500 persons) = 869,500 trainee-days
trainee days for HA (20,889 persons) = 752,004 trainee-days
trainee days for AHI (4,200 persons) = 88,200 trainee-days
trainee days for HI (460 persons) = 9,660 trainee-days
trainee days for SI (460 persons) = 9,660 trainee-days
trainee days for FPI (4,500 persons) = 126,000 trainee-days

In addition to the above mentioned needs, there will be further need for refreshers training and orientation. Also, there will be need-based training depending on epidemiological pattern of various geographical areas of Bangladesh.

k. Utilization of Local Training Institutes

All the FWVTIs and RTCs visited were found well equipped for training in terms of physical and other logistic facilities including availability of trained faculty members. However, **these are lying almost un-utilized for almost three** (in some instances more) **years.** FWVTIs had been designed to provide basic and refreshers training for Family Welfare Visitors. Almost all the FWVTIs have at least two well equipped training rooms and residential facilities for 60 participants at a time. The MATSs also have similar facilities.

l. Linkages of UMIS, PMIS and TMIS

Under HPSP, a three-tier training management information system (TMIS) has been developed. As per design, TMIS has to generate training information and to ensure its flow to TTU, D/UTT and DTCC, enabling the managers to carry out various management and planning related activities on in-service training at their respective level. Training as a whole along with in-service training has become an integral part of HPSP. It appears TMIS has also been linked with PMIS of UMIS as an important subsystem of the latter.

5. Decentralized IST: Long-term Vision

a. In-service training should be aimed at continuous improvement of skills and knowledge of both the trainers and trainees – at all levels – ultimately to improve the health status of people, especially the poor, women and children. Considering the vastness of the Bangladesh Health and Population Sector Program which intends to reach 130 million population with 100 million in the rural areas through nearly 150,000 health and population sector staff spread over 64 districts, 468 upazilas, 4556 Unions and over 90,000 villages – **decentralization of in-service training is a must to ensure cost-effecient and need-based training and orientation at the grassroots level.**

b. It is important to note that, **Decentralized In-service Training** must be viewed as an integral part of overall decentralization of administration and governance. This implies that decentralized IST will not generate intended impact in isolation wherein **key authority is centralized but many responsibilities are decentralized,** where plans are still top-down with little considerations to the bottom-up approaches, where stakeholders participation in planning and implementation is still at an embryonic (experimentation) stage.

c. The desired level of success of decentralized IST is contingent upon decentralization of many functions which are still centralized due to various reasons. Devolution of authority and responsibility is needed. Among the functional aspects retarding the process of decentralized IST, the most prominent one is decentralization of funds i.e; timely availability of fund to DTCC without any interruption and without intermediaries.

d. **A long-term planning vision for decentralized IST** needs to be worked out. Such long-term planning vision for decentralized IST should consider and include, among others, the following:

i. **Plan should be** based on **in-depth assessment** of existing skill and knowledge-base of training providers (persons and institutions) available at the local levels (primarily at union, upazila, district).

ii. **Planning matrix should** take care of the gap between the existing skill mix and the potential demand for skill-mix to provide increasingly demanding health and population sector services (in line with ESP) for each type of service provider.

iii. **Planning exercise should consider prioritized training needs.** Such prioritization needs to be done keeping in mind the national context (training on a common issue for specific type(s) of service providers) and the regional and local contexts (i.e; consider regional, local epidemiological patterns). In which case, the **local level participatory planning exercises for IST is a must.**

iv. **Management and financial sustainability of decentralized IST should be the key component in the long-term planning vision.** In order to ensure management sustainability, among others, it would be necessary to work out means and ways to maximize capacity utilization of the locally existing training institutions (facilities) and the training personnel; and all possible efforts should be made to continuously improve the quality of trainers. In order to facilitate the process of financial sustainability of decentralized IST, it would be appropriate to expand the market for training. In this connection, in order to **build-up a resource base locally, selling of training expertise and training materials to various agencies** (IST to other govt. agencies, to NGOs, to private sectors) **deserve special considerations.**

v. **Smooth functioning and sustainability of decentralized IST will not be possible** without further strengthening of the **central level**. The central level should be adequately **professionally** equipped to facilitate the process of decentralized IST. Equipping the central level should include, among others, the following**:** strengthening capacity to produce uniform curriculum and guidelines for improvements in quality, improve capability in developing planning methodologies including methodology for needs assessments, formation and continuous updating of expert trainer's pool at the central and regional levels by subject areas, capacity building to ensure smooth coordination with DTCC (using PMIS and TMIS), organizing the process of training impact evaluation including evaluation of impact on service delivery (actual utilization of knowledge gained in training), capacity improvements for monitoring and supportive supervision of training, developing monitoring and evaluation tools, strengthening capacity to implement modular training.

4. Summary of Findings

- The D/UTT members expressed that, TOT **has enriched their individual capability** of performing as trainers. In general, those who had received TOT appeared to be more confident of conducting the training Program.
- DTCC and D/UTT formed by TTU have been observed **as an effective mechanism** for coordination, implementation and monitoring of local level training activities.
- The amount of **fund allocated** against each course (for DTCC, D/UTT, FWVTIs) was found **adequate to cover the expenses**.
- **90-95 percent of Trainers and Trainees** were found interested and eager to learn more to upgrade their knowledge and skills and **demanded more in-service training** with longer duration.
- **Role of LTO** as observed in one district (Comilla) was more or less satisfactory. It is a good system to start with provided LTO is sound and moves **with care and quality.**
- There **exists a huge unmet need for training** of different categories of field personnel. The estimated total additional (in addition to 21 days basic training on ESP) training required for the field service providers and their supervisors **would be 1.86 million trainee days.**
- The expertise of faculty members of FWVTIs are **partially utilized** when the training is conducted at FWVTIs, otherwise, they **remain idle most of the time.**
- **FWVTIs have little or no involvement** with the training conducted at Upazilla Health Complexes.
- In some places (Tangail, Bogra) **some positions** of members of DTCC/D-UTT are **vacant due** to transfer/retirement etc.
- The newly posted members of training **team have not yet received necessary training,** nor any formal orientation.
- **Meetings** of DTCC are **irregular and not appropriately documented.**
- Although according to the national strategy and action plan for decentralized-IST the **available representative of NIPORT** system at the district and upazilla level (FWVTI/ RTC) is a member of D/UTT, in reality the designated **team member position remains vacant.**

- The **approved AOP for** respective districts **were not communicated by** TTU to DTCC, and budget was not provided on time, therefore the training plan could not be materialized.

- **All the upazillas** (except former TFIPP, FIMC, and RTC upzillas) do not have well equipped training rooms, and **required logistic support including furniture, audio-visual equipment, white boards etc.**

- **Lack of availability of fund on regular basis is the single most important factor affecting planned implementation of in-service training** courses. Irregular fund flow has direct implications (retardation effect on the pace of training implementation) on the total process of implementation of decentralized-IST Program.

- There exists **directives about the distribution of sessions** to be covered by district and upazilla trainers, which **restrain the DTCC/DUTT to act freely** in choosing the right person as Trainer.

- In cases of **overlapping of training** in more **than two upazillas** (out of six) on the same day it **becomes difficult** for the chairpersons and the co-chairpersons to attend the opening and closing sessions. Apart from this, **proxy lectures** may have to be curtailed to maintain quality.

- In almost all districts, **structured follow-up and supportive supervision** has **not yet** been introduced.

- **There exists a mechanism at TTU**, which updates the training needs in the sector and the process of organizing TOT has been going on.

- The **district cost centre remains in darkness** regarding the timing of up-coming trainings planned to be held at district and at upazillas until they receive instructions from TTU.

- **TTU is** reported to be **facing difficulties** with adjustments of disbursed fund for training to district cost center, **due to delayed and/or incorrect submission of vouchers** against money spent by them (DTCC/D-UTT).

- The **lay-off situation that** prevailed **in the FWVTIs** after discontinuation of basic and refreshers' courses demoralized the staff. The training is also fully dependent on the fund flow and instruction from the central level.

- The **information available at district level and below are not regularly analyzed.** All of the prescribed formats of TMIS (post-training performance assessment, follow-up, etc.) has not been introduced and followed-up. **PMIS is weak and hardly exists.**

6. Follow-up of Study Findings

The team considers that unless a follow-up activity is embarked upon immediately, the expected output or outcome may not be visible from the present study. As such, it is strongly suggested that the follow-up action as stated below be initiated immediately.

***Hold Dissemination Workshop** at Division-level with the participation of DTCC, D/UTT members and key stakeholders on the findings of the study to:*

a. ***Sensitize** the lessons learnt;*

b. ***Arrive** at a consensus on a plan of action to institutionalize IST on long-term vision; and*

c. *A **workshop** Committee with LD-IST as convenor and with a HRD-GTZ representative as member plus all other concerned may be constituted to oversee the workshop. All 6-7 workshops be completed within 3-4 months.*

The flash-point in this exercise would be – **create confidence** in them about their capability and **recognize** their potentials for a sustainable IST at local level.